Office of Administration

Commissioner's Office

"Request for Preauthorization for Other Services"

Program: **Alternatives to Abortion**
Contractor: Nurses for Newborns
Subcontractor: N/A

Please enter below the information for each item/service to be purchased. List the date of purchase, item to be purchased, cost for the item, and the justification. Items must be approved **before** purchased/provided to be reimbursed.

Client Name: [redacted] *Date Enrolled:* _____

Proposed Purchase Date	Item	Total Cost (include formal estimate from provider of services)	Justification, include other sources of funding that have been attempted
Due 3/20/17	Car Payment	$247.76	Client has just returned to work & uses car to get to and from
AMOUNT TO BE REIMBURSED		$247.76	

Please return to Alternatives to Abortion Program Manager, State of Missouri – Office of Administration, Commissioner's Office, State Capitol Building, Room, 125, Jefferson City, MO 65101. May be faxed to 573/751-1212 or emailed to emily.kraft@oa.mo.gov by the Contractor only!

Thank you.

Authorized person requesting purchase: Jenny Uhlig

Approved for purchase: _____ Date _____

Purchase denied: _____ Date _____

Reason for denying purchase: _____

ALTERNATIVES TO ABORTION PROGRAM
Assistance Request

This form is to be completed by an NFN Nurse ONLY and must be completed entirely for timely approval and submission.

DATE: 3 / 17 / 17 CLIENT NAME: [redacted]

The above named client is requesting assistance through NFN's ATA Program for the following:

____ **Rent**
(if new request, a W-9 and Lease MUST accompany this form)

____ **Utility**
(if Ameren, provide account number and account holder's name; if Laclede, provide bill)

X **Transportation**
(if new request, no additional information is needed; if repeat request for gas card ONLY, please provide receipts)

____ **Other**
(Pre-Authorization Request and documentation of the bill/invoice/etc. to be paid MUST accompany this form)

Landlord/Utility/Other NAME: Midwest Acceptance

BILL TOTAL: $ 247.76 AMOUNT YOU ARE PAYING: $ 40 AMOUNT REQUESTED: $ 207.76

OTHER RESOURCES ATTEMPTED FOR ASSISTANCE (must list at least three):

1. [redacted]
2.
3.

Agency Representative: _____
Agency Representative: _____
Agency Representative: _____

I understand this is a one-time payment. This assistance is intended to assist you in the delivery of a healthy baby or in keeping your child on target developmentally. I have completed a ***Budget Form*** *and* ***Individualized Pregnancy Continuation Plan*** *(IPCP) with my nurse in order to ensure my ability to pay*

[redacted] 3/17/17
(date)

[redacted] 3/17/17
(RN signature) (date)

IPCP Completed/Submitted: JV (initial) Budget Form Completed: JV (initial)

Date Received: _____ Date Pledged/Submitted for Payment: _____